

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Marshall Health Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 16 Beal Street MacHias, ME 04654	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, review of the facility's Abuse Policy and Procedure and interview, the facility failed to report an injury of unknown origin to the State Agency for 1 of 4 sampled resident who had an injury of unknown origin. On 8/19/25, a review of R1's clinical record was completed. Documentation indicated R1 has many diagnoses including mental health issues, dementia and cognitive impairments. Documentation in a nurse's note dated 7/24/25, indicated that in the early evening R1 told a staff member that they had injured their finger. When asked what happened, R1 told the nurse it happened from a fall. On 8/19/25 at 9:45 a.m., in an interview with Certified Nurse Assistant #1 (CNA1), she stated the resident told her it happened when she fell, but did not know where or when. CNA1 stated the resident is not reliable in what he/she says. CNA1 stated the resident has behavior problems and could have hurt her finger in a number of different ways. A review of the facility's Abuse Policy and Procedure indicated under the Section: Reporting Allegations to the Administrator and Authorities: #1 If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown origin source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. #2 The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency. On 8/19/25 at 10:45 a.m. in an interview with the surveyor, the Administrator and the Assistant Director of Nursing (ADON) stated R1 has impaired cognition and mental health diagnoses. The ADON stated when they were notified of the incident, they were told that the resident said she fell out of bed. The ADON stated it was an unwitnessed fall with injury. The resident is a poor historian, and it could have been a fall or something else could have caused the injury. The Administrator confirmed that the resident's recall of events could be unreliable, and the injury was of unknown origin and should have been reported to the State Agency.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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